DBVI-70-004
Revised 12/00 J/F 07/03

DEPARTMENT FOR THE BLIND AND VISION IMPAIRED
Health Checklist/General Medical Examination

SECTION I: Health Checklist (completed by counselor)

Name:

Address:

Social Security #:

D.O.B.:

Height: Weight:

Send Report To:

Check "Yes" for any condition that you have ever had. Explain "Yes" items that have made it hard for you to find or keep a job or to take care of your home.

Medical History (circle appropriate symptom)	**Remarks (give details for any "Yes" answers)**
No Eyes, ears, nose, or throat	
No Seizures, fainting, headache	
No Lungs, shortness of breath, asthma, Emphysema, habitual cough, allergies	
No Stroke or paralysis	
No Mental or nervous disorder	
No Heart, chest pain, high blood pressure	
No Stomach, ulcer, gall bladder	
No Kidney, bladder, prostrate or reproduction system	
No Diabetes, thyroid	
No Arthritis, back, extremities	
No Amputation or loss of use of any body part	
No Tumor, cancer, tuberculosis	
No Anemia or other blood disorder	
No Hospital, surgery	
No Excessive use of alcohol, drugs	
No Other: (specify)	

Name of your personal physician/clinic: (If none, so state)

Date(s) and reason(s) you consulted your physician/clinic/emergency room in the last 2 years:

What medications are you now taking?

Are you under any medical restrictions?

Other physical or mental conditions you may have? Explain:

_____ _____

(Date) (Counselor signature)

SECTION II: COMPLETED BY THE PHYSICIAN

This evaluation is needed to determine the degree of impairment so that the rehabilitation counselor may determine ability, an employment objective, and a plan of service(s). Please review with the customer all positive responses to the screened history recorded on the front of this form, and record additional history, findings, and your opinion as to whether they have current significance or need further study. Please note any discrepancy between apparent medical status and customer statement or handicap. Please discuss your findings with the customer.

PART II:

	PHYSICAL EXAMINATION
	Eyes
	Ears, nose, throat
	Mouth, teeth
	Neck, thyroid
	Lymphatic system
	Breasts
	Lungs, chest
	Heart
	Abdomen, hernia
	Genitalia, pelvic
	Genito—urinary
	Ano-rectal
	Limbs, joints, spine
	Edema, varicose veins
	Neurological, gait
	Psychiatric
	General appearance

Serology Data *	Height	Weight	Blood Pressure
Test	Urinalysis	Albumin	Sugar
Results			

*Optional Test(s)

PART III:

Present illness/describe abnormalities in PART I:

PART IV – DIAGNOSIS

1. Primary Condition:
2. Acute: □ Chronic: □ Stable: □ Improving: □ Progressive: □ Transient: □ Permanent: □
3. Secondary condition(s): (specify):

PART V: Please check your opinion as to work tolerance. Functional restrictions are based on non-visual capacities.
Functional and/or environmental limitations:

1. Walking: □ UNLIMITED	□ 1-2 MILES	□ 1 ½ - 1 MILE	□ 1-2 BLOCKS	□ 100 FT/LESS
2. Stairs: □ UNLIMITED	□ 4 FLIGHTS	□ 2 FLIGHTS	□ 1-2 FLIGHTS	□ NONE
3. Lifting: □ 60-100 LBS	□ 40-60 LBS	□ 25-40 LBS	□ 10-25 LBS	□ 10 LBS/LESS
4. Standing: □ UNLIMITED	□ 75% OF TIME	□ 50%-75% OF TIME	□ 25%-50% OF TIME	□ 10% OR LESS
5. Stooping, Bending, Twisting:	□ UNLIMITED	□ RESTRICTED	□ AVOID	
6. Temperature Extremes:	□ UNLIMITED	□ RESTRICTED	□ AVOID	
7. Other Limitation:				

PART VI – Comments and recommendations:

1. Indicate need for additional medical supplies:
2. Can these be accomplished on outpatient basis? □ Yes □ No If yes, where?
3. Indicate needed treatment(s):
4. Indicate needed surgical procedure(s): 5. CPT Code:
6. Hospitalization: □ Yes □ No 7. Name of hospital: 8. No. of days:
9. Prognosis for employment? With treatment: Without treatment:

(Signature of Physician) (Date)

(Address)

(Specialty)

(F.T.I.D.)

FOR DBVI USE ONLY: (When appropriate)

(Signature of Physician)

(Review Date)